CHANCES FOR CHILDREN – NY

EVALUATION OF RESULTS FOR SERVICES DELIVERED

2016 – 2017

chances for children

DATA EVALUATION REPORT

Chances for Children – NY (CFC) is pleased to submit the following evaluation of results for services delivered in our three locations in the Bronx - Kingsbridge, Highbridge, and Hunts Point. Results are for services delivered from July 1, 2016 thru June 30, 2017. (In June 2017, CFC began providing services in a fourth community, Mott Haven, at Paul's House, a facility of Sheltering Arms. This report does not include data from that site.)

SUMMARY OF CFC SERVICES

CFC provides interventions for parents and children birth to 5 years old in three areas in the Bronx with few treatment options for children under 5. Participation in the program includes 1 hour dyadic meetings with a trained parent-child specialist for a renewable series of 15-week sessions, and/or weekly, parent-child groups. Service offerings depend on the needs and wants of the families. (CFC also offers training in infant mental health and specifically in this protocol through the Chances for Children Institute at RMHA.)

WHAT WE DO:

CFC provides free mental health services to families with children birth to 5 years old language

Dyadic sessions use the CFC protocol that is an evidence-based, best-practices model using video-recorded parent-child interaction and feedback. Both group and dyadic interventions are used to:

- strengthen and solidify bonds of attachment between parent and infant,
- improve parenting skills, including the ability to anticipate and appropriately respond to developmental changes in the infant over time,
- increase positive verbal and non-verbal interactions between parent and child,
- assess and provide treatment for mental conditions such as depression, anxiety or post-traumatic stress in both parent and child.

All CFC services are offered free of charge. We provide both preventive and post foster-placement interventions for parents and children. We partner with three other agencies, Hunts Point Alliance for Children (HPAC), Kingsbridge Heights Community Center (KHCC), and most recently Sheltering Arms Paul's House, to provide services onsite at their locations.

The program allows us to detect, prevent and intervene with psychological problems early in the life of the child and family both before abuse happens and after disruption has occurred**.** We expect to achieve improved maternal and child relationships that support the social-emotional development of children. Research has shown that babies (and toddlers) can't wait. The first three years of life is an especially crucial period in brain development with 700 neural connections made every second. Early experiences, relationships and environments shape the brain's development. Early experiences become the basis for how a child will interpret future experiences. Early relationships create a working-model for what it is like to be in relationships with other people and creates a sense of self in relation to others. Strong relationships and quality parenting that builds those relationships are the bases on which infant's and children's mental

health is built. Research has shown the far-reaching impact of early relationships and quality parenting on school readiness[i], health outcomes[ii] and success in adulthood[iii].

EVALUATION OF DYADIC PROGRAM

CFC evaluates its outcomes every year. We use the KIPS *(Keys to Interactive Parenting Scale)* scale to evaluate the interaction between parent and child, the NDDS *(Nipissing District Developmental Scale)* scale to identify developmental delays and an Evaluation of Satisfaction Scale.

In dyadic and group interventions, CFC served 103 dyads (206 individuals) this year.

A statistically significant improvement in key parenting behaviors was found after CFC intervention.

Since 2011 when we began using KIPS, CFC has shown statistical improvement across all domains of targeted parenting skills.

CFC believes that evaluation of direct services is the best measure of the success of both its training program and clinical service. Positive results indicate solid training of staff and good clinical outcomes. CFC aims to achieve the following in our direct service with families: 1. *Improved parent behavior* that emphasizes thoughtful reflection over impulsive reaction, non-punitive limit setting and responsiveness to children's cues, all of which are shown to reduce risk of abusive/neglectful parenting. 2. *Timely referral* to early intervention services so children enter school ready to learn, and 3. *Client satisfaction* with services provided.

These three domains were measured as follows:

1. *Improved parenting behavior* was measured from pre-/post-intervention video recordings rated according to the *Keys to Interactive Parenting Scale (KIPS)* written by Marilee Comfort, PhD, and Phil Gordon, PhD. This scale measures a number of areas identified in the literature as critical to healthy child development such as parent sensitivity of response, engagement in language experiences, promotion of curiosity and exploration and effective limit setting.
2. *Identification and referral of children* needing early intervention services and referrals to appropriate agencies was assessed using the *Nipissing District Developmental Scale (NDDS)* of child development.
3. *Client satisfaction* with provided service is reported in a Likert scale *Client Satisfaction Inventory* designed by CFC.

Referral Sources:

The following chart reflects the sources for our referrals in this evaluation period.

Source	Percentage of Referrals
Foster care agency	7.5%
Family Court	11.2%
WIC	6.7%
Nurse Family Partnership	3%
Hospital/Medical Clinic	26.3%
Parent called agency	7.5%

HPAC	10.5%
KCHC	16.5%
Sheltering Arms* (new)	3.75%
Other	3%

Demographic Information: Dyadic Program	
For All Families Referred: (n= 133)	
Ethnicity:	68.10% Latino; 20.40% African American; 3.03% Caucasian; 4.50% Not Recorded; 0.76% African, Chinese, Eidian
Foster care involvement:	10 %
For Families with at least 5 Sessions*: (n=86)	
Children's gender:	57% Male, 40% Female, 3% Not Recorded
For Families with Completed Data: (n= 33)	
Parents under a court mandate:	10%
Parents scoring as depressed on screenings:	15.62% (general population: 6.7%[1])
*This is the number of families new to CFC in the evaluation period that have completed at least 5 sessions.	

Dyadic Program Information	
# Dyadic sessions scheduled:	1268
# Dyadic sessions attended:	819 64.59% attendance)
Total referrals 2016-2017:	133
#Dyads that completed intervention:	33
# Dyads in progress**:**	31
# Dyads prematurely discharged** (these dyads have had at least 5 sessions)	22
# Dyads that never began services:	45
**Parents are prematurely discharged for many reasons, most frequently a move to a different neighborhood from a shelter or an inability to manage the multiple services required of them. Nevertheless, these families have received the benefit of many CFC interventions that would include: 1. Video recording with feedback 2. An introduction to one of the domains of the CFC protocol 3. A developmental screening of their child and referral to appropriate services when indicated.	

CFC served 85 families this year in its dyadic program. We have a full data set for 32 families, 31 are still in progress, and an additional 22 families attended at least 5 sessions of intervention.

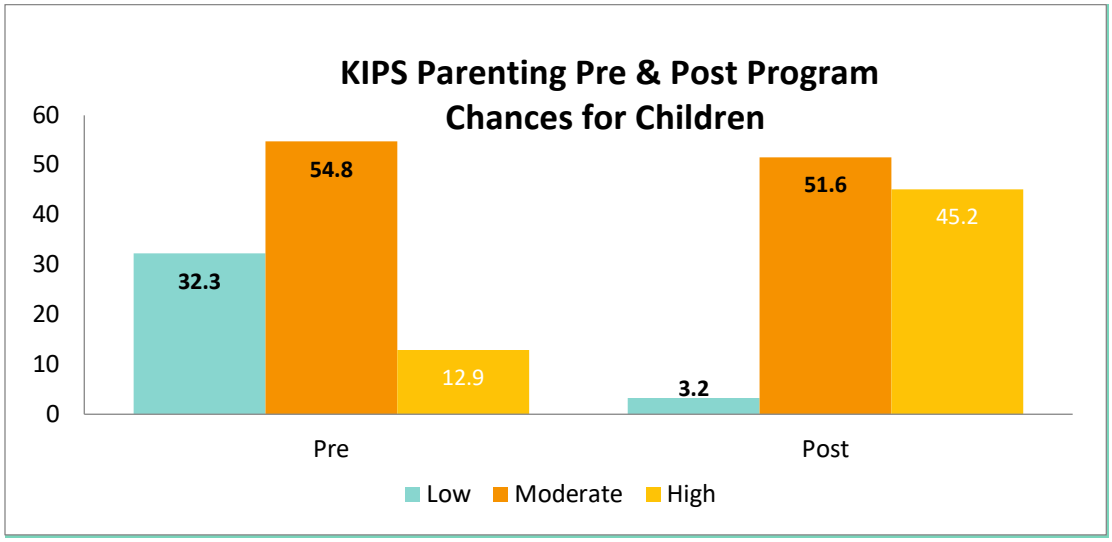
[1] Statistic on rate of depression is from adaa.org

THE THREE DOMAINS EVALUATED:

1. Improved parent behavior, including parental sensitivity of responses, engagement in language experiences, promotion of curiosity and exploration and effective limit setting:

The data reported here are ONLY families for whom we have full data (32) who completed the CFC program during the period from July 1, 2016 to June 30, 2017.

The following chart reflects the QUALITY OF PARENTING of all dyads before and after intervention. Quality of parenting was measured using video recording of dyads pre- and post-intervention. Videos were coded by raters certified reliable by the KIPS organization who were blind to the time of recording. No coder saw the same family in both pre- and post-recording.



Parenting skills shifted towards higher quality parenting after the program. At baseline, prior to CFC intervention, parenting skills were heavily Low or Moderate (86.6%). After the program, many parents had shifted upward a category or even two categories, with the bulk being Moderate to High. Almost half (44.8%) showed high quality parenting after the program. *This improvement in Parenting Quality was statistically significant, (McNemar-Bowker Chi-Sq=14.455, df=3, p=.002.*

	Pre-Intervention		Post-Intervention	
Parenting Quality	**Number**	**%**	**Number**	**%**
LOW (below 3)	10	32.3 %	1	3.2 %
MODERATE (3-4)	17	54.8 %	16	51.6 %
HIGH (4.1-5)	4	12.9 %	14	45.2 %

The KIPS instrument groups 12 items into three areas of parenting behaviors:

Building Relationships	**Promoting Learning**	**Supporting Confidence**
Sensitivity of Responses Supports Emotions Physical Interaction Involvement in C's Activity Open to Child's Agenda	Language Experiences Reasonable Expectations Adapts Strategy to Child Limits & Consequences	Supportive Directions Encouragement Promotes Exploration/Curiosity

BUILDING RELATIONSHIPS:
How does supporting emotions help to build relationships?

If a child becomes frustrated with a task like trying to build a block tower that repeatedly falls, if a parent says "Oh Boy! That is really frustrating! Would you like some help?" the child will feel understood, respected, and will now have the language to label the feelings he is having. This builds trust and reciprocity that is unlike the experience incurred if a parent ignores the trouble or says "Oh, never mind; it is only some blocks."

PROMOTING LEARNING:
How does adapting strategies to the child's interests help promote learning?

Children may wander from toy to toy without becoming engaged with focused attention. When a parent adjusts the activity to capture the child's interest and expands the activity rather than changing it, a child increases her attention span and creativity.

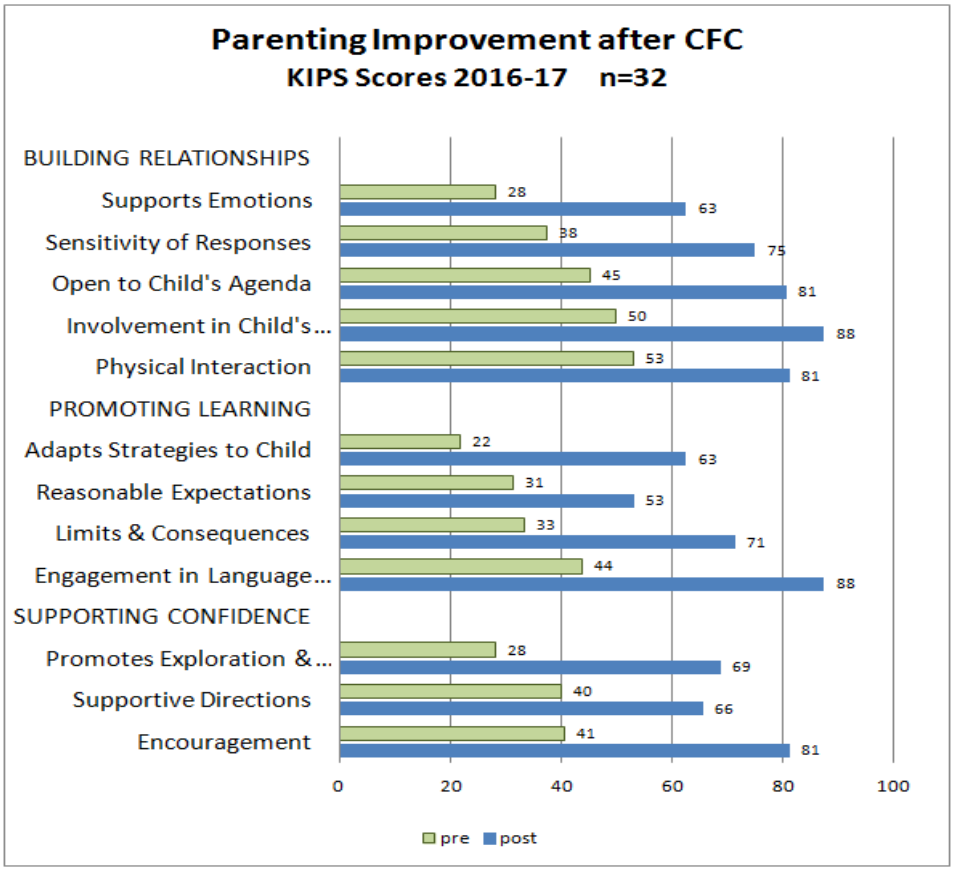
SUPPORTING CONFIDENCE:
How do encouraging words and actions help children develop confidence?

Frequently when a child is trying to do something (make a drawing), a parent may take the crayon and do it for her rather than helping the child do it herself- this can be discouraging to the child who quickly loses interest and changes activities. An alternative might be to say: "What else does a face have besides eyes?" Here the child not only learns body parts, but learns that mommy can be counted on to make things feel good. The child learns "I can do it!"

After participating in Chances for Children, parents improved their parenting in all areas.
Parents increased by an average of .67, 63 and .68 points for Building Relationships, Promoting Learning and Supporting Confidence respectively.

KIPS Improvements by Parenting Category 2016-17			
	Pre *Mean (SD)*	Post *Mean (SD)*	p-value
Building Relationships	3.41 (.75)	4.09 (.64)	p<.001
Promoting Learning	3.21 (.69)	3.84 (.59)	p<.001
Supporting Confidence	3.24 (.74)	3.92 (.77)	p<.001

Note: Values are mean scores on a 5-point scale



2. Referral to Early Intervention and other services: 13 dyads were identified as needing further services; all were referred and received services.

3. Client satisfaction:

This year CFC piloted a new instrument to measure client satisfaction to better capture elements of the client dyadic experience with CFC. This measure was developed in the fall and administered beginning January 2017. Surveys are offered in both English and Spanish. Surveys are handed out and anonymously returned in a self-addressed stamped envelope. At this time we have fifteen completed surveys. *All parents reported feeling welcomed and accepted by CFC, were satisfied with their experience with CFC and would recommend the program to other parents. 14 of 15 felt they better understood their child's point of view. No participants reported that CFC had not been useful to them or that their CFC provider was not interested in them or did not listen.* (Please see appendix for full inventory).

As in the past, these surveys were administered at the end of a client's participation in services. As was discussed in last year's report, one of the limitations of a survey at the end of the program is the loss of information from parents who dropped out of the program which leads to a self-selected pool of subjects. Having tweaked the questions subsequent to this pilot test, we are now ready to begin to collect information earlier and more frequently during a family's participation.

Exit Interview Results 2016-2017:Dyadic Program n=15	
	% Agree or Strongly Agree
Agreed on goals	100
Gives me new ways of thinking about parenting	93
Has not been useful to me and my child	0
Felt accepted and welcomed in the CFC program	100
Feel I can better understand the world from my child's point of view.	93
Believe CFC helped me think differently about my situation	93
Believe my child had a good experience in the CFC program	93
Feel provider is not interested in my thoughts (*does not listen to me*)	7
Believe the way we are working with my situation is helpful.	100
Satisfied with my experience in the CFC program.	100
Feel comfortable recommending the CFC program to other parents	100

ACCUMULTED RESULTS ACROSS THE YEARS 2011- 2017

Starting in 2011, CFC began using the KIPS instrument for evaluation. In the six years from 2011 to 2017 we have KIPS data on 169 dyads. At baseline, KIPS scores were in the poor range (KIPS below 3.0) for 41.4% (n=70) of parents. Another 46.2% (n=78) had baseline KIPS scores in the moderate quality parenting range (KIPS 3.0-4.0). So the bulk of parents, 87.6%, had parenting scores that could improve. (During this period, 12.4% of parents (n=21) began the program with high quality parenting skills. These parents were referred for issues unrelated to their parenting (death, medical treatments or developmental concerns) and thus the KIPS measurement does not capture the success of the interventions offered).

After completing the CFC program, 91.4% (64 of 70) parents with low parenting scores had improved to medium or high quality parenting (50.0% of parents to medium; 41.4% to high quality). For the 78 parents whose parenting before CFC was of medium quality, 61.5% improved to high quality parenting.

Testing these changes statistically, we find that indeed there is a statistically significant improvement in KIPS parenting categories after participation in Chances for Children. [McNemar-Bowker Chi-Sq=100.817, df=3, p<.001]

EVALUATION OF GROUP PROGRAM

Groups take place at CFC-NY's Highbridge office two mornings a week and last 90 minutes. Parent-child dyads may attend until the child is 2.9 years old. This year there were three 12-15 week semesters (fall: 2 groups; winter: 2 groups; summer: 1 group.) There is a routine followed each week that includes singing, free play, story and snack, parent discussion and dance. The group sessions are structured around a theme that is presented during parent discussion and applied during free play. The focus of all groups is to build positive relationships between parents and their children. More specifically, we aim: to improve the parent-child relationship, to aid parents in finding appropriate limit setting strategies, to relieve isolation, and to help parents feel less stressed and more effective as caregivers. Our referrals for group come from a variety of organizations including: Nurse Family Partnership, preventive service and foster care agencies, pre-schools, WIC and medical clinics.

The group also serves as a support to the dyadic services. This year two families were referred from the dyadic program to the group because of the needs of the parent and child.

Group Demographics 9/2016-7/2017	
Number of families	**17**
Ethnicity	70.5 Latino, 17.6 African-American, 5.9 African, 5.9 Caribbean,
Children's gender	6 Male, 11 Female
Parents under a court mandate	1
Referred to or from CFC dyadic treatment	2 Dyads
Foster care involvement	0
Single parent household	3
Referred for evaluation	0
Grandparent	2
Father	2

EFFICACY EVALUATION OF GROUP: PILOT PROJECT

CFC continues to explore ways to evaluate the efficacy of our therapeutic groups. This year CFC created and piloted an observation tool called the HIPPRS (Highbridge Infant, Parent, Peer, Rating Scale.) It includes four subscales: Parent Scale, Infant Scale, Dyadic Scale and Peer

Scale and records both positive behaviors (enjoyment, positive eye contact, ability to play) and negative behaviors: (withdrawal, disinterest in child, interest without engagement.)

Observations are conducted in real time during group. Each dyad is observed for 10 minutes and each behavior is rated on a 4 point scale. In this pilot project we wanted to test: 1. Could the scale be administered in 10 minutes per dyad without disrupting the group; 2. did the observations align with the group leaders' clinical assessments of the dyad, and 3. were there any changes in the interactions from the beginning of the group to the end? All of these questions were answered in the affirmative. We will make some changes in the recording system that will be more user friendly and a formal statistical system will be created.

REFERRALS FOR OTHER SERVICES

As in the past, the Nipissing District Developmental Screen (NDDS) is administered at different times during the group semester to evaluate the developmental stage of each child. If there is any concern from the group leaders or the parents about a child's development, the group leaders discuss this with the parents and appropriate referrals are made for the child. This year there were no referrals made for the children attending groups.

A BONUS: A NUTRITION WORKSHOP

This year CFC was able to provide a nutrition workshop for the group members. CFC staff worked with a nutritionist to design a workshop for the families. It was very well received. Parents expressed their concerns about their children's eating habits - mostly that the children did not eat enough - and the nutritionist reassured them about nutritional needs of children. The most effective part of the workshop was when the nutritionist asked parents to observe the interaction of each dyad when both parent and child were given the opportunity to eat a piece of apple. Did the parent allow the child to make choices about what they wanted to eat? Did the children say they weren't hungry but when left alone eat the apple in their hand? When did the parent interfere with their child's autonomy about food? Why was it difficult for a parent to step back and observe rather than actively to engage with child around the food?

One couple brought their 1 1/2 year old son. They were concerned because he wouldn't eat when his mother gave him food and asked him to sit at the table to eat. Both parents were losing patience because their son would sit on his father's lap while the father was eating later in the evening and eat the father's food. The dad said: "I was bothered when he sat on my lap and ate my food off of my plate after he had refused his own food earlier. Now I understand that he was doing this because he wanted to be with me, not to bother me. It makes me feel good that he wants to sit on my lap; it's a way he can be with me. I know I won't be annoyed now."

CLIENT SATISFACTION

CFC-NY continues to explore the best ways to evaluate group satisfaction. This year we continued to use an exit survey from the parents in order for us to assess the experience and quality of the parent-child groups. This survey is scored by a 5-point Likert Scale: 1- Strongly Disagree to 5-Strongly agree. Of the 17 families attending group this year 10 have completed the satisfaction surveys. The remaining 7 families attended one semester but had to leave the group before the last meeting when the satisfaction survey is given. (Reasons for leaving the group include: 2 parents returned to work; 2 families moved from NYC; 3 families had responsibilities that made it impossible for them to attend.) Of the ten families who completed Satisfaction Surveys to date ***all agreed or strongly agreed*** that:

- they were treated with respect and courtesy,
- the environment was welcoming and that both they and their children felt comfortable in the group,
- they saw a change in their own ability to see the world through their children's eyes,
- they use strategies learned in the group at home as well as sing songs and recreate activities, and
- they all endorsed being willing to recommend the group to other parents.

In the words of a father who began group when his son was 5 months old:

"Because of what I've learned in this group I have a different relationship with my child than with the older one. I don't get angry and annoyed with him…even on the subway we play and laugh together. I tell the people I work with about this group. I come even when I have been working very late the day before. It's important for me and my child to be here."

CONCLUSION

CFC is proud to show continued positive outcomes resulting from our clinical work. As we continue to expand our services to more areas of the Bronx, we see daily the obstacles that cyclical poverty and trauma inflict on so many in these communities. Each family presents its own challenges, and we continue to work to find the best ways to evaluate our therapeutic interventions with them. While these evaluations provide data-based evidence of our work's impact, the most gratifying measure of our success continues to be the small steps we see families take every day, as struggling moms and dads gain the skills to be the parents their children need.

Clinical Vignette: When Cultures Collide

Ms. F came to the US on a student visa, completed her studies and went to work as an accountant. Sometime later she became pregnant and though not married, she and the baby's father planned together for the child. Ms. F was thrilled with the opportunity to raise her child in America. Having had an extremely strict and frightening childhood herself in a culture with a

rigid and punitive structure for raising children, she wanted her child to be raised with love. Frequently beaten by their parents, she and her school friends had only each other for comfort when their kindergarten teacher began to fondle them one by one. There was no adult to turn to for protection, no child protective service, only each other. “We didn’t have childhood”, she explained, “they beat us a lot. It’s not like here.”

Ms. F had an uneventful pregnancy with prenatal care, but she had had some reservations about other medical care she had received previously and was wary of hospitals. As it happened, the morning of a prenatal appointment, she went suddenly into labor and delivered a healthy 7 lb. baby, alone in her apartment. This was not unusual in her culture, and she managed remarkably by following the customs she had been taught. Sometime later in the day, the hospital phoned asking why she had missed her appointment. She answered honestly, saying she and the baby were fine. The hospital sent EMS to her home and demanded that she go to the hospital with the baby. She refused and closed the door. Police were called and she and the baby were taken by force to the hospital. Exceedingly distressed she began talking about the situation to anyone who would listen. The hospital called ACS (child protective services), and demanded that the child be placed in foster care, as in their view, Ms. F was not competent to care for her child. The child was removed immediately.

That was 4 months ago. Since then her four-month-old baby has been in three different foster homes, and Ms. F has been fighting to get her back. Among the services mandated for her by the court was dyadic therapy. Having completed her other services, and frustrated that her caseworker had not found a program for her, Ms. F found CFC online and referred herself to us. Ms. F has been an eager and reliable participant, always prompt and responsive, overjoyed to see her baby, lapping up information. Nevertheless, she struggles with the differences in cultures between her birth culture and the “American way”. Caught between East and West, she cannot decide what she wants for her baby and her stress level makes it difficult for her to think clearly. “I think this whole situation has given me PTSD,” she remarked recently. “I am so stressed. When the baby cries now, I feel panic.”

How does a mother establish a protective, comforting relationship with a baby under these circumstances? This is the dilemma CFC faces with her weekly, offering the best support we can to reduce her anxiety and give her coping strategies to manage herself and her child. Yet every moment of her interaction is watched, judged and documented by those around her, giving her no time to come to know this new being, or for them to begin to understand one another -- let alone make, and learn from, the mistakes all new parents make. The lack of opportunity to experience motherhood routinely is compounded by her ambivalence about which cultural customs to follow, what language to talk or sing in and what the baby should or shouldn’t eat. Now estranged from the baby’s father who has another family, Ms. F has little external support and a lot of fear. It is our hope to be able to see this baby home to her mother and to provide Ms. F with the skills, confidence, and courage she will need to make thoughtful choices and realize her dream of raising a child with love.

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[i] Kauffman Foundation Report (2002). Set for Success: Building a Strong Foundation for School Readiness Based on the Social-Emotional Development of Young Children. This is a report on a conference held by the Kauffman

that looked at factors contributing to school readiness. Major factors in school readiness include things like the ability to pay attention, cooperate with others, get along with peers and teachers, and be excited & confident about learning about the world.

[ii] The Adverse Childhood Experiences (ACE) Study. Center for Disease Control and Prevention. Retrieved on August 26, 2016. A study of 10 types of childhood trauma and the impact and cumulative impact of those early experiences have to health problems decades later.

[iii] Emmy Werner, Zero to Three, vol. 20 (4), 2000. Werner reports on a forty-year longitudinal study of individuals from infancy to adulthood. She has found that effective early relationships were major contributors to success in adulthood. She defined success in adulthood as an individual having a strong family, being employed, being drug and alcohol-free and being a responsible citizen.